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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	LIFE CARE ATHENS
AND HUMAN SERVICES	

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1). PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE : COMPI	(X3) DATE SURVEY COMPLETED	
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LIFE CA	PROVIDER OR SUPPLIER RE CENTER OF ATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 1234 FRYE STREET, PO BOX 788 ATHENS, TN, 37371	1 0000	12013
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F 164 SS=D	The resident has the confidentiality of his records. Personal privacy in medical treatment, communications, privacy in meetings of family a does not require the room for each resident release of personal individual outside the The resident's right and clinical records resident is transferr institution; or record The facility must ke contained in the resident form or storage release is required in healthcare institution contract; or the resident by: This REQUIREMENT by: Based on observat	e right to personal privacy and or her personal and clinical cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this efacility to provide a private ent. In paragraph (e)(3) of this it may approve or refuse the and clinical records to any efacility. to refuse release of personal does not apply when the ed to another health care release is required by law. ep confidential all information ident's records, regardless of methods, except when by transfer to another it, law; third party payment dent. IT is not met as evidenced ion and interview, the facility nity for one (#40) of thirty-five	F 16	What corrective action(s) will be accomplished for those residents have been affected by the deficient practice; Resident #40 curtain was pulled the the way by CNA #4 on 8/5/13 immediated for the way by CNA #4 on 8/5/13 immediated by Unit Manager on 8/5/15 ensure that residents who are expensivelying in bed and in view to the half concealed by a privacy curtain and resident dignity is being met. How you will identify other resid having the potential to be affected and what corrective action will be taken; All residents that reside in the facilithe potential to be affected. License non-licensed staff will be educated Staff Development Coordinator by to ensure that residents who are expenditelying in bed and in view to the hallway are concealed by a privacy and that resident dignity is being much what systematic changes you will ensure that the deficient practice recur; Licensed and non-licensed staff will ensure that the deficient practice recur; Licensed and non-licensed staff will ensure that residents who are exposibling in bed and in view to the hall concealed by the Staff Development Coordinator upon hire and annually ensure that residents who are exposibling in bed and in view to the hall concealed by a privacy curtain and resident dignity is being met. Observed the conducted by Unit Manager in the conducted by Unit Manag	found to nt e rest of nediately is 13 to sed while way are that ents d by the 8/26/13 posed he curtain let. llace or make to does not ll be y to sed while way are that rvation	09/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Executive Director Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is defermined that other safeguards provide sufficient protection to the patients, (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

08/27/2013 13:01 4237459257 LIFE CARE ATHENS AT7 DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE 08/32 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING_ 445298 B. WING 08/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1234 FRYE STREET, PO BOX 786 LIFE CARE CENTER OF ATHENS ATHENS, TN 37371 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 164 weekly X4 and Monthly X2 to ensure that Continued From page 1 F 164 resident dignity is being met. Resident #40 was re-admitted to the facility on January 25, 2013, with diagnoses including How the corrective action(s) will be Diabetes Mellitus, Dementia, Hypertension. monitored to ensure the deficient practice Abnormal Gait, and Abdominal Aorta Aneurysm. will not recur; i.e., what quality assurance program will be put into place. Observation on August 5, 2013, at 3:20 p.m., in the resident's room revealed the resident was Audit results will be reported by the lying on the bed with a brief in place with the Director of Nursing to the Performance privacy curtain drawn part of the way. Continued Improvement Committee monthly for 3 observation revealed the privacy curtain was not months or until 100% compliance is pulled far enough to conceal the resident wearing achieved. The Performance Improvement the brief and exposed to view from the hallway. Committee will review these results; and if deemed necessary by the committee, Interview with Certified Nurse Assistant #4 on additional corrective action(s), measures, August 5, 2013, at 1:20 p.m., confirmed the and/or systematic changes may be initiated. dignity of the resident was not provided when the curtain was not pulled far enough to conceal the resident wearing the brief and exposed to view from the hallway. F 221 483.13(a) RIGHT TO BE FREE FROM F 221 What corrective action(s) will be 09/26/13 SS=D PHYSICAL RESTRAINTS accomplished for those residents found to have been affected by the deficient The resident has the right to be free from any practice; physical restraints imposed for purposes of Resident #113 and #152 initial restraint

discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced bν:

Based on medical record review, review of facility policy, observation, and interview, the facility failed to assess for the use of restraints for two residents (#113, #152) of thirty-five residents reviewed.

The findings included:

assessments were completed by the Director of Nursing on 8/5/13.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents that reside in the facility that utilize a contour mattress and foam rolls have the potential to be affected, 100% of residents utilizing a contour mattress and foam rolls were assessed for the use of restraints by the Assistant Director of

LIFE CARE ATHENS AT7

CENTE	<u>RS FOR MEDICARE</u>	E & MEDICAID SERVICES			PURM APPRUYE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/07/2013
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	Resident #113 was 31, 2013, with diagr Healing Left Hip Fra Behavloral Disturbal Medical record revied Data Set (MDS) data resident had severe required extensive a and no restraints in Medical record revied May 31, 2013, revea approach for a restraint of dated June 9, 2 found sitting next to mattress" Medical record revied dated June 14, 2013 jump out of bedwe barrier at the side of Medical record revied to dated June 16, was found on perime bedsidesuggestion Medical record revied dated June 21, 2013 used. Medical record revied dated June 21, 2013 used. Medical record revied dated June 21, 2013, to safely transition from positionpatient is a	admitted to the facility on May noses including Dementia, acture, Anemia, and ances. ew of the quarterly Minimum ted July 27, 2013, revealed the acognitive impairment, assistance of two for transfer, use. ew of the Care Plan dated aled no problem, goal, and/or aint. ew of a Post Fall Screening 2013, revealed "resident bedsuggestions: contour ew of a Nursing Home Note 3, revealed "attempting to a are going to put some if the bed" ew of a Post Fall Screening 2013, revealed "resident eter mat at at 1s: foam rolls to bed" ew of a Post Fall Screening 2013, revealed "resident eter mat at 1s: foam rolls to bed" ew of a Post Fall Screening 2013, revealed "resident eter mat at 1s: foam rolls to bed" ew of a Plan of Treatment revealed "the patient is able om suplne to sitting able to safely transfer from	F 22	Nursing on 8/6/13. Director of Nurs Staff Development Coordinator edulicensed nursing staff on 8/7/13 to e that residents are assessed for the us restraints prior to the placement of a mattress and/or feam rolls. What measures will be put into plus what systematic changes you will ensure that the deficient practice arecur: Licensed nursing staff will be educated the Staff Development Coordinator thire and annually to ensure that residuancement of a contour mattress and rolls. Assistant Director of Nursing a complete a 100% audit of residents areceive new orders for a contour mattress and rolls. Assistant Director of Nursing and/or foam rolls weekly X4 and measure that the initial restraint assessment is completed prior to implementation. How the corrective action(s) will be monitored to ensure the deficient paid in the recur; i.e., what quality as program will be put into place. Audit results will be reported by the Director of Nursing to the Performant Improvement Committee monthly for months or until 100% compliance is achieved. The Performance Improve Committee will review these results; deemed necessary by the committee, additional corrective action(s), measured.	acated ensure se of a contour ace or make to does not ted by upon dents are or to the for foam will who ttress onthly ace practice surance ace ar 3 ment cand if mres,
Į.	to safely transition from positionpatient is a bed to wheelchair"	ible to safely transfer from			

08/27/2013 13:01 4237459257 DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			•	FORM	APPROVED
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F 221	Medical record revie Recapitulation Orde revealed "Contour	ew of the Physician's ers dated August 2013 r Mattress to BedFoam Rolls	F 2	221	1		
	To Bilat (bilateral) Side Parameter" Medical record revies Restraint Assessment revealed restraint critical the word positioning	ew of Initial and Quarterly ent dated August 5, 2013, rossed out and replaced with 1. Continued medical review					
	toam rollres has p Medical record revie	revealed "res (resident) has poor safety awareness" ew revealed no restraint use of the contour mattress			,	-	·
	order is required to a restraintDocument includes type of restraint toleranceRestraint unsupervised ambut documented impaire skillsThe interdisct	tation in nurses' notes traint, date, time of use					
	the resident's room, on the side of the be contour mattress, fer yelling "I need help." revealed the left side contour mattress in p	rust 5, 2013, at 11:35 a.m., in revealed the resident sitting ad, legs over the foam roll and set not touching the floor, "Continued observation e of the bed against the wall, place and a foam roll placed side of the bed against the	. •				

F 221 | Continued From page 4

contour mattress.

STATEMENT OF DEFICIENCIES

LIFE CARE ATHENS AT7

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	
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OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
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 	RE CENTER OF ATH		1	234 FRYE STREET, PO BOX 786 THENS, TN 37371		
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F 221

Observation on August 5, 2013, at 4:14 p.m., in the resident's room revealed the resident sitting on the side of the bed, legs over the foam roll and contour mattress, feet not touching the floor, yelling "I can't get up." Continued observation revealed the left side of the bed against the wall, contour mattress in place and a foam roll placed parallel to the right side of the bed against the COntour mattress.

Observation on August 5, 2013, at 4:15 p.m., with the Assistant Director of Nursing (ADON), in resident #113's room revealed the resident sitting on the side of the bed attempting to exit the bed, yelling "t can't get up."

Interview on August 5, 2013, at 4:15 p.m., in resident #113's room, with the ADON confirmed the resident could not remove the foam roll and the resident could exit the bed if the foam roll had not been in place.

Interview on August 6, 2013, at 2:16 p.m., with the Director of Nursing (DON), in the DON's office, confirmed no assessment had been completed for the use of the contour mattress and the foam rolls as a restraint.

Resident #152 was admitted to the facility on December 13, 2012, with diagnoses of Chronic Airway Obstruction, Coal Workers Pneumoconiosis, Hypertension, and Dementia with Behavioral Disturbances.

Review of the Comprehensive Minimum Data Set (MDS) dated June 24, 2013, revealed the resident was severely cognitively impaired,

Event ID: P05M11

Facility IO: TN5402

If continuation sheet Page 5 of 21

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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		ON	MB NO. 0938-039
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F 221	required extensive and ally living, had upp limitations in range restraints while in a Continued review rebed restraints in use Observation of the revealed the resider parallel to the conto sheets, on the exit subservation reveale was against the wal Review of the Initial Assessment dated adocumentation of the Interview with the Difference of the Interview with	assistance with activities of er and lower extremity of motion and used physical chair or out of bed. evealed no documentation of e. resident on August 6-7, 2013, ats bed with a foam roll lying ur mattress, beneath the bed side of the bed. Continued d the opposite side of the bed l. and Quarterly Restraint June 19, 2013, revealed no e use of bed restraints. ON, on August 7, 2013, at	F 221		
F 226 SS=D	9:30 a.m., in the DO facility had failed to a contour mattress with 483.13(e) DEVELOR ABUSE/NEGLECT. The facility must developolicies and procedumistreatment, neglet and misappropriation by: Based on medical a review of facility investigating policies, the facility policies, the facility policies, the facility policies, the facility policies.	N's office confirmed the assess the foam roll and in bed bolsters as restraints. PIMPLMENT ETC POLICIES refor and implement written	F 226	What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice; Statement was received from CNA #1 E Director of Nursing on 8/6/13. Regional Vice President and Regional Director of Clinical Services educated Executive Director and Director of Nursing on facility's policy and procedure for investigating an allegation of abuse on 8/7/13.	yy

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLANT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
, man 4 may 4	AN CONNECTION	(DENTIFICATION NUMBER:	A. BUILD		COMPLETED			
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F 226	Continued From pa		E:	226	How you will identify other resident	ts		
!		e abuse investigations			having the potential to be affected be same deficient practice and what corrective action will be taken;			
!	The findings include	ed:		-]	
	Resident #77 was a 3, 2013, with diagno Mellitus, Cellulitis, C Decubitus Ulcer, an Interview with the re 12:27 p.m., in the re resident had reporte one month ago a Ce (CNA) had tried to k	admitted to the facility on May bees including Diabetes Congestive Heart Failure, and Hypertension. Besident on August 6, 2013, at esident's room revealed the ed to the facility approximately entified Nursing Assistant			All residents that reside in the facility the potential to be affected. All other a investigations that were conducted by facility after the Health and Life Safet Code recertification survey conducted 10/31/11 were reviewed by the Region Director of Clinical Services, Executive Director and Director of Nursing on 8/with no other concerns identified. What measures will be put into place what systematic changes you will make the deficient practice do recur;	abuse the y on al /e /7/13		
	CNA's present at the	e time of the incident.			All abuse investigations will be review	ed by		
	p.m., in the conferer revealed CNA #3 ha the incident on May being present in the incident and the aller to kiss the resident. Interview with CNA # p.m., in the conferent	#3 on August 6, 2013, at 3:32 nce room via telephone at written a statement about 27, 2013. CNA #3 confirmed room at the time of the ged perpetrator had not tried #1 on August 6, 2013, at 4:05 nce room via telephone, at not written a statement			the Executive Director, Director of Nu Regional Vice President and Regional Director of Clinical Services to ensure the facility followed policy and proced for investigating an allegation of abuse Regional Vice President and/or Region Director of Clinical Services will audit 100% of facility abuse investigations v X4 and monthly X2 to ensure that the facility followed policy and procedure investigating an allegation of abuse. As	that lure . The pai veekly	ا پی	
į	stating "I was not a CNA #1 confirmed be the time of the incide perpetrator had not t Interview with Regist August 6, 2013, at 4:	asked to give a statement" eing present in the room at			results will be reported to the Executive Director by the Regional Vice Presider and/or Regional Director of Clinical Services to report to the Performance Improvement Committee.	e		

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<u>MEDICAID SERVICES</u> OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X8) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING 445298 B. WING 08/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1234 FRYE STREET, PO BOX 786 LIFE CARE CENTER OF ATHENS ATHENS, TN 37371 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XE) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 226 | Continued From page 7 How the corrective action(s) will be F 226 abuse the day after the event occurred which was monitored to ensure the deficient practice when the resident reported the incident. Further will not recur; i.e., what quality assurance interview confirmed a witness statement was program will be put into place. obtained from CNA #3, but had not been obtained Audit results will be reported by the from CNA#1 because CNA#1 was not working Executive Director to the Performance on May 27, 2013. Improvement Committee monthly for 3 months or until 100% compliance is Review of facility policy and procedure, Abuse achieved. The Performance Improvement and for Neglect Investigation, revised February 2009 revealed "...investigation shall include a Committee will review these results: and if deemed necessary by the committee, written summary of ... interviews with any additional corrective action(s), measures, witnesses to the incident..." and/or systematic changes may be initiated. interview with the Director of Nursing (DON), on August 7, 2013, at 9:00 a.m., in the DON office, revealed the facility's policy was to "...typically perform interviews..." when investigating abuse allegations. The DON confirmed the facility had failed to obtain a witness statement from CNA#1 and the facility's policy for investigating allegations of abuse had not been followed, 483.20(d), 483.20(k)(1) DEVELOP F 279 F 279 What corrective action(s) will be **0**9/26/13 **COMPREHENSIVE CARE PLANS** SS=D accomplished for those residents found to have been affected by the deficient A facility must use the results of the assessment practice; to develop, review and revise the resident's comprehensive plan of care. Resident #43 care plan was updated to reflect instructions for knee braces, pressure The facility must develop a comprehensive care relief cushions, and/or positioning in the plan for each resident that includes measurable wheelchair by the Care Plan Coordinator on objectives and timetables to meet a resident's 8/6/13. Resident #120 care plan was updated medical, nursing, and mental and psychosocial to reflect blood pressure/blood draw needs that are identified in the comprehensive precautions in the extremity with the shunt assessment. by the Care Plan Coordinator on 8/6/13. Care Plan Coordinators were educated by The care plan must describe the services that are the Director of Nursing on \$/6/13 to ensure

to be furnished to attain or maintain the resident's

highest practicable physical, mental, and

care plans/care directives include

instructions for knee braces, pressure relief

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LIFE CARE ATHENS ATT DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING COMPLETED 445298 **B. WING** 08/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF ATHENS 1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) F 279 Continued From page 8 cushions, and/or positioning in the F 279 wheelchair and that blood pressures/blood psychosocial well-being as required under draw precautions are care planned. §483.25; and any services that would otherwise be required under §483.25 but are not provided How you will identify other residents due to the resident's exercise of rights under having the potential to be affected by the §483.10, including the right to refuse treatment same deficient practice and what under §483.10(b)(4).

This REQUIREMENT is not met as evidenced

Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for two residents (#43, #120) of thirty-five residents reviewed.

The findings included:

Resident #43 was admitted to the facility on September 9, 2013, with diagnoses including Depression, Dementia, Congestive Heart Failure, and Abnormality of Gait.

Medical record review of the quarterly Minimum Data Set (MDS) dated July 11, 2013, revealed the resident was severely impaired cognitively and required limited assistance of one for locomotion off the unit with guided maneuvering of limbs.

Medical record review of the Care Plan last updated July 24, 2013, revealed no care plan for a knee brace, pressure relief cushion, and/or positioning.

Medical record review of a Nursing Rehabilitation/Restorative Care form dated March 12, 2013, revealed "...apply brace to R (right) knee..."

Medical record review of a Rehabilitation Services

corrective action will be taken:

All residents that reside in the facility have the potential to be affected. 100% audit of resident care plans and care directives was started by the Care Plan Coordinators on 8/6/13 and will be completed by 9/26/13 to ensure that care plans/care directives include instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care planned. Licensed nursing staff will be educated by the Director of Nursing and/or Staff Development Coordinator by 8/26/13 to ensure care plans/care directives include instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care planned.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:

Licensed nursing staff will be educated by the Staff Development Coordinator upon hire and annually to ensure care plans/care directives include instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care

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	PROVIDER OR SUPPLIER RE CENTER OF ATHE			8	YREET ADDRESS, CITY, STATE, ZIP CODE 234 FRYE STREET, PO BOX 786 ATHENS, TN 37371		07/2013
PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(XS) COMPLETION DATE
	Multidisciplinary Scr 2013, revealed "N benefit from a press issued today" Medical record revie (Certified Nurse Aid 2013, revealed no ir pressure relief cush wheelchair. Observation on Aug the West Wing Hall pushing the resident pressure relief cush revealed the resident unable to reach the knee. Observation on Aug the West Wing revealed the resident unable to reach the knee. Observation on Aug the West Wing revealed a pressure bilateral legs without on the right knee. Interview with the Di August 6, 2013, at 1: Nurses Station confinclude any approach knee brace to the right pressure relief cushi positioning. Resident #120 was a 5, 2011, with diagnos Renal Disease, Diab	reening Tool dated July 17, lo functional changeswould sure relief cushion which was aw of a Care Directive to care plan) dated August 5, instructions for knee brace, iton, and/or positioning in the sust 5, 2013, at 11:37 a.m., on revealed a staff member at in the wheelchair with a iton. Continued observation in the support floor and a brace on the right sust 6, 2013, at 1:00 p.m., on aled the resident propelling in. Continued observation relief cushion in place, at support, and a knee brace in the care Plan did not the care Plan did not the or interventions for the ght knee for contractures, ion to the wheelchair, and/or admitted to the facility on July ses including End Stage	F 2	79	planned. Assistant Director of Nursing complete a 10% audit of resident care and care directives weekly X4 and mo X2 to ensure care plans/care directive include instructions for knee braces, pressure relief cushions, and/or position in the wheelchair and that blood pressures/blood draw precautions are planned. How the corrective action(s) will be monitored to ensure the deficient provial not recur; i.e., what quality assignogram will be put into place. Audit results will be reported by the Director of Nursing to the Performance Improvement Committee monthly for months or until 100% compliance is achieved. The Performance Improvem Committee will review these results; a deemed necessary by the committee, additional corrective action(s), measure and/or systematic changes may be init	plans onthly s oning care ractice urance 3 nent and if	

PAGE 17/32

DEPAR CENTE	I'MENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	PPROVE
STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IB NO. 0 X3) DATE S COMPL	
		445298	B. WING	<u> </u>	UGTUZ	72013
	PROVIDER OR SUPPLIER RE CENTER OF ATHE	NS .	1	STREET ADDRÉSS, CITY, STATE, ZIP CODE 1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371	USIU/	<u>/2013</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E C	(X5) COMPLETION DATE
F 279	"shunt to left arm. Care Plan revealed address blood press the left arm. Observation on Augrevealed resident #1 observation revealed shunt to the left arm. Interview with the De August 6, 2013, at 1	ted June 12, 2013, revealed" Continued review of the the Care Plan did not sure/ blood draw precaution in ust 7, 2013, at 9:34 s.m., 20 resting in bed. Continued d the resident with a dialysis ON, in the DON's office, on :24 p.m., confirmed the care blood pressures/ blood draw	F 279			
SS=D	483.20(d)(3), 483.10 PARTICIPATE PLAN	(k)(2) RIGHT TO INING CARE-REVISE CP	F 280	What corrective action(s) will be accomplished for those residents found have been affected by the deficient practice;	d to	09/26/13

FORM CMS-2567(02-99) Previous Versions Obsolete

each assessment.

incapacitated under the laws of the State, to

participate in planning care and treatment or

A comprehensive care plan must be developed within 7 days after the completion of the

interdisciplinary team, that includes the attending

disciplines as determined by the resident's needs.

and, to the extent practicable, the participation of the resident, the resident's family or the resident's

legal representative; and periodically reviewed

and revised by a team of qualified persons after

physician, a registered nurse with responsibility

for the resident, and other appropriate staff in

comprehensive assessment; prepared by an

changes in care and treatment.

Event ID: P05M11

Facility ID: TN5402

Resident #40 care plan was updated to

How you will identify other residents

All residents with a behavior of exposure

of resident care plans with a behavior of exposure was started by the Care Plan

completed by 9/26/13 to ensure that care

plans include approaches to address the resident's behavior of exposing self. Licensed nursing staff will be educated by

Coordinators on 8/7/13 and will be

have the potential to be affected. 100% audit

having the potential to be affected by the

resident's behavior of exposing self by the

include approaches of addressing the

Care Plan Coordinator on 8/7/13.

same deficient practice and what

corrective action will be taken;

If continuation sheet Page 11 of 21

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		FORM APPROVI
TATEL ATTO SERVICE SERVICES	(94) 5551	(X2) MULTIPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY

OTATEL ACT.		A MILDIONID SELAICES				<u>DMB NO</u>	. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445298	B. WING			na	07/2013
NAME OF	PROVIDER OR SUPPLIER		' 	STREE	TADDRESS, CITY, STATE, ZIP CODE	1 001	VIIZU 13
I IEE AA	DE AEUTED AC JEUG	1416			FRYE STREET, PO BOX 786		
LIFE CA	RE CENTER OF ATHE	NS	}		INS, TN 37371		
(X4) 1D	SHAMARYSTA	TEMENT OF DEFICIENCIES	, f				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIT TAG	,	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(XS) COMPLETION DATE
F 280		ge 11 IT is not met as evidenced	F2	De en be	e Director of Nursing and/or Staff evelopment Coordinator by 8/26/1 sure that resident care plans with thavior of exposure include approa	3 to 1 ches to	
	by: Based on medical and interview, the faplan to address digrammers digrammers.	record review, observation, acility failed to revise the care nity for one (#40) of thirty-five		ad se: W wi	ldress the resident's behavior of ex	posing ace or nake to	
	January 25, 2013, w Diabetes Mellitus, D	ea: -admitted to the facility on with diagnoses including tementia, Hypertension, Abdominal Aorta Aneurysm.		Lie the hir pla	censed nursing staff will be educate Staff Development Coordinator are and annually to ensure that residents with a behavior of exposure improaches to address the resident's	ipon ent care	
	Medical record revie dated January 25, 2 keep Brief Pulled Do while in bed" No a resident's behavior of	ew of the resident's Care Plan 013, revealed "Pt. (patient) own and stays uncovered approaches to address the of exposure were found.		bel of res we res	havior of exposing self. Assistant I Nursing will complete a 10% audi ident care plans with a behavior ex eakly X4 and monthly X2 to ensur- ident care plans with a behavior of posure include approaches to addra ident's behavior of exposing self.	t of cposure: that	4
	the resident's room: lying on the bed wea curtain was drawn p observation revealed pulled far enough to	ust 5, 2013, at 3:20 p.m., in revealed the resident was aring a brief and the privacy art way. Continued of the privacy curtain was not conceal the resident wearing to view from the hallway.		Ho ,mo wil pre	ow the corrective action(s) will be positioned to ensure the deficient pull not recur; i.e., what quality assogram will be put into place. Idit results will be reported by the	ractice Surance	*** <u>-</u>
F 309 \$S=D	(MDS #1) on August MDS office confirme the resident's behav implemented.	um Data Set Coordinator 7, 2013, at 8:45 a.m., in the rd no approaches to address ior of exposing self had been ARE/SERVICES FOR	F 30	Imj mo ach Cor dec 39 add	rector of Nursing to the Performan provement Committee monthly for with or until 100% compliance is nieved. The Performance Improvemented will review these results; and necessary by the committee, litional corrective action(s), measured or systematic changes may be in	r 3 went and if rres,	09/26/13

LIFE CARE ATHENS AT7

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CENTE	RS FOR MEDICARI	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVE 0. 0938-039
			TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED	
		445298	B. WING			/07/2042
	PROVIDER OR SUPPLIER RE CENTER OF ATHI	ENS		STREET ADDRESS, CITY, STATE, ZE 1234 FRYE STREET, PO BOX 789 ATHENS, TN 37371	P ÇODE	<u>/07/2</u> 013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFD TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	Each resident must provide the necess or maintain the high mental, and psychologocordance with the and plan of care. This REQUIREMENT by: Based on medical and interview, the factorious provides the medical provides the medical and interview, the factorious provides the medical provides	t receive and the facility must ary care and services to attain nest practicable physical, usocial well-being, in a comprehensive assessment of the process	F 30	accomplished for those reshave been affected by the practice; Resident #43 was assessed five occupational therapy on #120 Physician was notified Nursing and clarification or received for dialysis on 8/6/ How you will identify othe having the potential to be a same deficient practice and	idents found to deficient for positioning 8/6/13. Resident by Director of ders were 13. It residents affected by the d what	
	positioning of one resident (#43), and failed to obtain a physician's order for dialysis for one resident (#120) of thirty-five residents reviewed. The findings included: Resident #43 was admitted to the facility on September 9, 2013, with diagnoses including Depression, Dementia, Congestive Heart Fallure, and Abnormality of Galt. Medical record review of the quarterly Minimum Data Set (MDS) dated July 11, 2013, revealed the resident was severely impaired cognitively and required limited assistance of one for locomotion off the unit with guided maneuvering of limbs. Medical record review of the Care Plan last updated July 24, 2013, revealed no care plan for a knee brace, pressure relief cushion, and/or positioning.			All residents that reside in the utilize pressure rollef cushion receiving dialysis have the plaffected. Staff Development will educate licensed staff by ensure that residents are evaluated the placed. Director of educated Health Information Director on 8/6/13 to ensure dialysis orders are printed or physician recapitulation order of residents that utilize pressoushions to evaluate for proposers attend on 8/6/13 by octherapy and will be completed. All residents that receive dialysician that the Physician recapitulation orders were obtained by the Director of National Clarification orders were obtained.	ne facility that ms and/or obtential to be Coordinator y 9/6/13 to luated for proper relief cushion Nursing Management that resident in the monthly ars. 100% audit nure relief per positioning cupational ed by 9/26/13. llysis were ursing on 8/6/13 was notified and	· · · · · · · · · · · · · · · · · · ·
- 1	Rehabilitation/Resto	rative Care form dated March apply brace to R (right)				

knee...*

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DEPARTMENT OF REALTH AND MINARY OFFICER

		I AND HUMAN SERVICES				*******	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION DENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A BUILDING). 0938-039 TE SURVEY MPLETED	
		445298	B. WING	;			iozianan
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	10	<i>1</i> 07/2013
LIFE CA	RE CENTER OF ATHE	ins		1	294 FRYE STREET, PO BOX 786 ATHENS, TN 37371		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) AF	(XS) COMPLETION DATE
·	Multidisciplinary Scr 2013, revealed "N benefit from a press issued today" Medical record revie (Certified Nurse Aid 2013, revealed no ir pressure relief cush Observation on Aug the West Wing Hall pushing the resident Continued observatilegs without support and a brace on the resident to West Wing revealed the bilatera knee brace on the righterview with Physic 2013, at 1:10 p.m., in	ew of a Rehabilitation Services reening Tool dated July 17, to functional changeswould sure relief cushion which was ew of a Care Directive a care plan) dated August 5, astructions for knee brace, ion, and/or positioning. The wheelchair. T	F	909	What measures will be put into place what systematic changes you will measure that the deficient practice do recur; Licensed staff will be educated by the Development Coordinator upon hire at annually to ensure that residents are evaluated for proper positioning after a pressure relief cushion has been placed residents admitted on dialysis will be reviewed by Assistant Director of Numersure that dialysis order has been obtaind written on the monthly physician recapitulation orders. Director of Reha Services will complete a 10% audit of residents that utilize pressure relief cus weekly X4 and monthly X2 to ensure they were evaluated for proper position Director of Nursing will audit 100% of residents admitted on dialysis weekly and monthly X2 to ensure that dialysis has been obtain and written on the morphysician recapitulation orders. How the corrective action(s) will be monitored to ensure the deficient prowill not recur; i.e., what quality assurprogram will be put into place.	Staff and a l. All sing to ain be all shious that along. If X4 order athly	
	Interview with the Dir August 6, 2013, at 1: Nurse's Station reve	rector of Nursing (DON) on 38 p.m., in the West Wing aled Occupational Therapy sident on July 17, 2013, and			Audit results will be reported by the Director of Rehab Services and Director Nursing to the Performance Improvem Committee monthly for 3 months or un 100% compliance is achieved. The Performance Improvement Committee	ent ntil	

a new pressure cushion had been placed in the

revealed the cushion prevented the resident's feet

resident's wheelchair. Continued Interview

from touching the floor. Further interview

confirmed the facility had failed to evaluate the

review these results; and if deemed

necessary by the committee, additional

corrective action(s), measures, and/or

systematic changes may be initiated.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) D A. BUILDING C		
1111		445298	B. WING		08/07/2013	
i	PROVIDER OR SUPPLIER RE CENTER OF ATHE	'NS	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371		4112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(205) COMPLETION DATE
F 312 SS=D	resident for position been applied to the Resident #120 was 5, 2011, with diagnor Renal Disease, Dial Medical record reviet last updated June 1. 3d (three days)" Or review of the curren Orders signed July 9 documentation of an Interview with the DA August 6, 2013, at 1 facility failed to obtain 483.25(a)(3) ADL CADEPENDENT RESIDENT	ing after the cushion had wheelchair. admitted to the facility on July uses including End Stage betes, and Nephritis. The current Care Plan 2, 2013, revealed "dialysis continued medical record to Physician Recapitulation of corder for dialysis. ON, in the DON's office, on 124 p.m., confirmed the in an order for dialysis.	F 309	F312 What corrective action(s) will be accomplished for those residents for have been affected by the deficient practice; Resident #40 toenails were trimmed by Treatment Nurse on 8/7/13. How you will identify other resident having the potential to be affected by same deficient practice and what corrective action will be taken;	ts by the have esident it will	09/26/13
ļ	by: Based on observation	T is not met as evidenced on and interview, the facility care for one (#40) resident of evidenced.		What measures will be put into place what systematic changes you will measure that the deficient practice do recur;	ake to es not	
	The findings included Resident #40 was re January 25, 2013, w Diabetes Mellitus, De	i i		Licensed and non-licensed nursing state to educated by the Staff Development Coordinator upon hire and annually to ensure that resident toenail care is produnit Managers and/or Treatment Nurs audit 10% of all residents weekly X4 amonthly X2 to ensure that resident nai is provided.	viđed, es wili and	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 445298 B. WING 08/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1234 FRYE STREET, PO BOX 786 LIFE CARE CENTER OF ATHENS ATHENS, TN 37371 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION IQ PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) How the corrective action(s) will be F 312 | Continued From page 15 F 312 monitored to ensure the deficient practice will not recur; i.e., what quality assurance. Observation on August 5, 2013, at 10:00 a.m., in program will be put into place. resident #40's room revealed the resident was lying on the bed with no socks or shoes and the Audit results will be reported by the resident's toenails were long and jagged. Director of Nursing to the Performance Improvement Committee monthly for 3 Observation and interview on August 7, 2013, at months or until 100% compliance is 8:50 a.m., with Minimum Data Set Coordinator #4 achieved. The Performance Improvement and Certified Nurse Assistant #5 In the resident's Committee will review these results; and if room confirmed the resident's toenails were long deemed necessary by the committee. and jagged and required trimming. additional corrective action(s), measures, F 371 483.35(i) FOOD PROCURE, and/or systematic changes may be initiated. F 371 STORE/PREPARE/SERVE - SANITARY SS≒F F371 The facility must -(1) Procure food from sources approved or What corrective action(s) will be 09/26/13 considered satisfactory by Federal, State or local accomplished for those residents found to authorities; and have been affected by the deficient (2) Store, prepare, distribute and serve food practice: under sanitary conditions The following observations made on 8/5/13 were corrected as followed: 1) Sprinkler head in walk-in refrigerator was wiped off and assessed by the Certified Dictary Manager and Director of Maintenance on This REQUIREMENT is not met as evidenced 8/5/13. 2) Spoiled tomatoes were disposed by: of by the Certified Dietary Manager on 8/5/13. 3) Ice build-up on door latch in the

Based on observation and interview, the facility dietary department failed to maintain dietary equipment in a sanitary manner.

The findings included:

Observation and interview with the Certified Dietary Manager on August 5, 2013, beginning at 9:08 a.m., confirmed the following:

1) The walk-in refrigerator had water dripping

Facility ID: TN5402

If continuation sheet Page 16 of 21

walk-in freezer was removed by the Director

and reach-in refrigerator/freezer doors were

and Dietary Aide on 8/5/13. 6) The reach-in refrigerator door gasket was cleaned by the

Certified Dietary Manager on 8/5/13. 7) The

cleaned by the Assistant Dietary Manager

of Maintenance on 8/5/13. 4) Ice cream freezer was defrosted to remove ice build-up

from chest interior by Dietary Aide on 8/10/13. 5) The exterior of the ovens, fryer,

PAGE 23/32 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES					APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
	445298	B. WING		<u>. </u>		A-1864
NAME OF PROVIDER OR SUPPLIER		' - -		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	07/2013
LIFE CARE CENTER OF ATHE	NS	İ	12	234 FRYE STREET, PO BOX 788		
Bro Es		<u> </u>	A	THENS, TN 37371		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
tomatoes stored in a 3) The walk-in freez on the door latch. 4) The ice cream freez build-up of Ice. 5) The exteriors of the refrigerator/freeze defended by the reach-in refrigerator freeze defended by the reach-in refrigerator defended debris. 3) The walk-in refrigerator defended debris. 3) The walk-in refrigerator defended debris. 4) The silver ware structured by the reach-in freeze debended debris defended debris. 5) The ice machine in a build-up of scale,	ead. Jerator had two spoiled a case of tornatoes. Jer door had a build-up of ice bezer chest interior had a he ovens, fryer, reach-in cors had debris present. Jerator door gasket had esent. Jerator had debris present. Jerator had a certified August 5, 2013, beginning at a the following: Jerator had a present. Jerator corners of Jerator corners of Jerator had a vacuum packed Jerator had a vacuum packed Jerator had an and an and debris present. Jerator had an and debris had an and spill pan slot had an an and spill pan slot had an and spill pan slot had an an and spill pan slot	F3	71	reach-in freezer door was cleaned by Certified Dietary Manager on 8/5/13. following observations made on 8/6/1 corrected as followed: 1) The shelvin storage unit on the right side as you e walk-in refrigerator was disposed of Director of Maintenance on 8/6/13. 2 supporting legs and shelves of the she unit containing clean dishes in the diswere cleaned by the Assistant Dietary Manager and Dietary Aide on 8/6/13. How you will identify other resident having the potential to be affected it same deficient practice and what corrective action will be taken; All residents that reside in the facility the potential to be affected. A dietary observation audit that included 100% following: 1) sprinkler heads in the warefrigerator, 2) produce storage, 3) fre 4) dietary equipment, 5) walk-in refrigerator/freezer doors and door gas and 6) shelving storage units was comby the Certified Dietary Manager on 8 to ensure that food storage and equipm maintained in a sanitary manner. Dietary Mill be educated to utilize routing cleaning and daily expiration check schedules by the Certified Dietary Maby 8/26/13 to ensure that food storage equipment is maintained in a sanitary manner. What measures will be put into place what systematic changes you will mensure that the deficient practice do recur;	The 3 were g nter the y the) The elving h room ts by the have of the alk-in ezers, pleted /6/13 nent is sury nger and	

Observation and interview with the Assistant

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FORM APPROVED .
OMB NO. 0938-0391

CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				1APPROVED 1. 0938 <u>-</u> 0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
4/4.500	·	445298	B. WING_		O.S.	<i>(</i> 07/2013
	PROVIDER OR SUPPLIER RE CENTER OF ATHE	ins .		STREET ADDRESS, CITY, STATE, ZIP CO 1234 FRYE STREET, PO BOX 788 ATHENS, TN 37371	DE J VO	10112013
(X4) ID PREFIX TAG	I LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD RE	(XS) COMPLETION DATE
F 371	Dietary Manager on 7:37 a.m., confirmed 7:37 a.m., confirmed 1) The shelving storyou enter the walk-in rusted shelves with on the shelves. 2) The shelving unit the dish room had a blackened debris or shelves. 483.60(b), (d), (e) DILABEL/STORE DRUTHE facility must email licensed pharmacing of records of receipt controlled drugs in saccurate reconciliation records are in order controlled drugs is not reconciled. Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable. In accordance with Sfacility must store all locked compartment controls, and permit have access to the keyout a shelp with the second story the second shelp with the second story and permit have access to the keyout and second shelp with the second shel	August 6, 2013, beginning at d the following: age unit on the right side as a refrigerator, had three various cases of food stored containing clean dishes in accumulation of sticky the supporting legs and RUG RECORDS, JGS & BIOLOGICALS ploy or obtain the services of six who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all naintained and periodically as used in the facility must be sewith currently accepted es, and include the ry and cautionary expiration date when State and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to	F 43	Dictary staff will be educated by Certified Dictary Manager upon annually to utilize routine clear expiration check schedules to enfood storage and equipment is a sanitary manner. Dictary obse audits will be completed by the Dictary Manager and/or Certific Manager to include: 1) sprinkle walk-in refrigerator, 2) produce freezers, 4) dictary equipment, refrigerator/freezer doors and deand 6) shelving storage units we monthly X2 to ensure that food	n hire and aing and daily insure that maintained in ervation. Assistant ed Dietary in heads in the storage, 3) 5) walk-in cor gaskets, eakly X4 and storage and nitary. The ent practice by assurance with the ent practice in th	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED 2MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		445298	B. WING_		00/07/04
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/07/2013
LIFE CA	RE CENTER OF ATHE	ins 		1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER(CIENCY)	D BE COMPLETION
F 431	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distrit	ge 18 compartments for storage of ed in Schedule II of the ig Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can	F 43	tubes of Capsaicin ointment, the ope coke, the three cans of disinfectant s and the two cans of air freshener and obtained a temperature gauge for the medication refrigerator on 8/6/13. How you will identify other resider having the potential to be affected same deficient practice and what corrective action will be taken;	n diet oray, nts by the
	by: Based on observation failed to appropriate chemicals and to more refrigerator storage is medication storage in the findings include. Observation of the 1 room on August 6, 2 Licensed Practical Notes that the top right cabinet two tubes of Capsaid colar, three cans of discussion storage in the top medication storage in the top refrigerator.	d: 00 hall medication storage 013, at 2:00 p.m., with urse (LPN #1) revealed in a bottle of rubbing alcohol, in ointment, an opened diet isinfectant spray and two r. Further observation of the ige room revealed no or the medication		All residents that have medications s the medication storage rooms have the potential to be affected. All facility medication rooms were audited by U Mangers on 8/7/13 to ensure that che and/or soft drinks are not stored with medications and that the medication refrigerators have a temperature gaugulace. Licensed nursing staff will be educated by the Director of Nursing staff Development Coordinator by 8/ to ensure that chemicals and/or soft d are not stored with medications and the medication refrigerators have a temperature in place. What measures will be put into place what systematic changes you will mensure that the deficient practice decreeur; Licensed nursing staff will be educated	nit micals e in and/or 26/13 rinks nat the exature exe or ake to pes not
F 465	LPN #1 confirmed the and the diet cola were	6, 2013, at 2:00 p.m., with e medications, chemicals, e not stored properly. with LPN #1 confirmed the cometer.	F 465	the Staff Development Coordinator up hire and annually to ensure that chem and/or soft drinks are not stored with medications and that the medication	oon icals e in
₹M CMS-25	37(02-99) Previous Versions O	bsolete Event ID: P05M11		acity to: TN5402	ry shoot Page 10 of 21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD CET

01	HURM APPROVED 1938-0391 <u>NB NO. 0938</u>
	(X3) DATE SURVEY COMPLETED

		G MEDICAID SERVICES			OI	MB NO.	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445298	B. WING	<u> </u>		001	07/2013
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	007	01/2013
LIEFOA	DE AENTED AE ASU-			1	1234 FRYE STREET, PO BOX 788		
ыге <u>ф</u> д	RE CENTER OF ATHE	:NS		1	ATHENS, TN 37371		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	l ID	_	PROVIDER'S PLAN OF CORRECTION		1 200
PRÉFIX TAG	! (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	ΊX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(XS) COMPLETION DATE
E 485	Continued E	40	_		100% of facility medication storage re	oms	
	Continued From pa		F4	465	weekly X4 and monthly X2 to ensure		
აა=D		L/SANITARY/COMFORTABL			chemicals and/or soft drinks are not st		
	E ENVIRON				with medications and that the medicat		
	The facility must are	udda a gafu filladdiau l	ł		refrigerators have a temperature gauge	≥in .	
	sanitary, and comfo	ovide a safe, functional, rtable environment for			place.	-	
	residents, staff and	tne public.			: How the corrective action(s) will be		
					monitored to ensure the deficient pr		
	This REAL HOUSE	T is not met as evidenced	İ		will not recur; i.e., what quality assu	irance	
	by:	ti is not met as evidenced			program will be put into place.		
		ion and interview, the facility			A 370	ł	
	falled to provide a s	anitary, odor free environment]		Audit results will be reported by the	_	
	for one (#40) of third	y-five residents reviewed.	•		Director of Nursing to the Performance		
i		,			Improvement Committee monthly for months or until 100% compliance is	ا د	
	The findings include	rđ:			achieved. The Performance Improvem		
`	•				Committee will review these results; a		
					deemed necessary by the committee,	uiu i	•
	Observation on Aug	ust 5, 2013, at 10:00 a.m., in			additional corrective action(s), measur	İ	
ł	resident #40's room	revealed a strong urine odor			and/or systematic changes may be init		
	and a sticky floor.	_			The state of the s	:	
	Observation on Aug	ust 6, 2013, at 8:00 a.m. and				1	•
	10:30 a.m., of the re	isident's room revealed the			F465	1	÷
	resident was out of t	he room and the bed was				[]:	
	made, and a strong	urine odor was present.			What corrective action(s) will be	1	09/26/13
	Internation is a				accomplished for those residents for	ınd to	
	Interview on August	6, 2013, at 8:43 a.m., with			have been affected by the deficient	- 1	
ļ	Licensed Practical N	lurse (LPN) # 3 and			practice;	1	
	nousekeeper#1 in t	he resident's room confirmed					
	the room had a strop	ng urine odor and the floor			Resident #40 room was cleaned and	_	
	was sticky. Continue	d interview with LPN #3			sanitized by environmental services of 8/6/13.	.	
		it's roommate urinates on the			0/0/13.	∦	
		ly and observed a yellowish			How you will identify other residents	₃	
	brown area on the fit beds.	oor between the resident's			having the potential to be affected by		
ł	DOUS.				same deficient practice and what	`	Į
ļ	Obcorretion and inte	mious on Assessed 7 0040 -		i	corrective action will be taken;		j
	8:50 a.m., with Minir	erview on August 7, 2013, at num Data Set Coordinator #1			All residents that reside in the facility i	nave	

and Certified Nurse Assistant #5 in the resident's

the potential to be affected. 100% of resident

LIFE CARE ATHENS AT7

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

		(X2) MU A. BUILL		(X3) DATE SURVEY COMPLETED			
445298		B. WING	B. WING			08/07/2013	
	PROVIDER OR SUPPLIER RECENTER OF ATHE	ins		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 234 FRYE STREET, PO BOX 786 THENS, TN 37371		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F-465		resident's room had a strong		485	rooms were audited by the Director of	fensure dor ices cotor of and ee or ake to es not aff ment are id/or ill 4 and ms actice irance	
					Improvement Committee will review to results; and if deemed necessary by the committee, additional corrective action measures, and/or systematic changes no initiated.	hese ; 1(s),	